DOCUMENT RESUME

ED 350 827 FL 020 526

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TITLE The Language of the Bilingual Medical Consultation.
PUB DATE 88
NOTE 8p.; In: Grunwell, Pamela, Ed. Applied Linguistics in Society. Papers from the Annual Meeting of the British Association for Applied Linguistics (20th, Nottingham, England, United Kingdom, September 1987. British Studies in Applied Linguistics, 3; see FL 020 520.
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adults; Applied Linguistics; *Communication Problems; Discourse Analysis; English; Gujarati; *Intercultural Communication; *Interpreters; *Interviews; Language Research; *Physician Patient Relationship; *Questioning Techniques; Uncommonly Taught Languages; Videotape Recordings

ABSTRACT

A study investigated translation problems arising in physician-patient interviews conducted in two languages with the help of an interpreter. Subjects were four adult native speakers of Gujarati, aged 42-70, whose physician interviews were videotape-recorded and translated, and the discourse was analyzed. Patients spoke in Gujarati, and the interpreters were family members. Questions were classified as simple, complex, or serial, and the frequency of each type was tabulated. Mistranslations in five categories (anatomical, symptoms and conditions, other terminology, euphemisms, loan words) were noted, and social and cultural factors evident in the exchanges were examined. It is concluded that while the interviews seem, on the surface and to the doctor, to be quite normal, they were often severely dysfunctional for linguistic and cultural reasons. The quality of information exchanged was such as to make correct initial diagnosis unlikely. Further study and consideration of the use of professional interpreters in such exchanges are recommended. (MSE)

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ED350827

THE LANGUAGE OF THE BILINGUAL MEDICAL CONSULTATION

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Introduction

Training in doctor-patient communication skills is now reasonably commonplace in medical training, with standard works written on the subject (Byrne and Long 1976), but it perhaps needs to be said that the term *communication skills* as understood by doctors does not necessarily imply linguistic analysis. The focus is on affect and on handling patients sensitively rather than on language form and function. We would assert therefore that applied linguists working in this area need to have a concern for the assimilability of the training models they propose. In addition, most work on communication skills in medicine deals only with monolingual settings, but in many urban areas in particular, the situation where doctor and patient do not share a common language is commonplace. Within the Asian population of Leicester, where the present writers work, 11,200 people speak little or no English as assessed by themselves. Of this number 6,500 are over 45, and it is this older segment of the population which makes the greatest demands on hospital services.

The medical interview is the basis of the diagnostic process, and requires both the doctor and the patient to understand each other fully in order that the maximum amount of information might be obtained by both parties. Obtaining a good case history from patients with a poor command of English involves using an interpreter who is assumed by the doctor to have a good command of both English and the patients mother tongue. We decided to look at the dynamics of the bilingual interview to assess how information was handled and to what extent information was misinterpreted.

Method

We observed four patients, who were all Gujarati speakers, aged between 42 and 70 and who had previously attended an outpatients' department. They had agreed to have an interview with a doctor video recorded and they attended with an interpreter of their choice. The interview was conducted as if this was their first visit to an outpatients' department at the hospital, and lasted for about thirty minutes. Each patient spoke in Gujarati and the interpreter was in each case a family member - husband, son, daughter or grandson. The Gujarati sections of the videotapes were subsequently translated into English and analysed.

FL 020 526

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Results

The basic discourse structure of the consultation, repeated many times across the four interviews, was that a question from the doctor to elicit information was translated, or mistranslated, into Gujarati, sometimes with editing. The patient responded and the interpreter translated into English, or mistranslated or edited. The doctor then either followed up with a related question, or started a new line of enquiry. A typical example of this pattern is:

Doctor:	Is it fair to say she usually produced phlegm with the cold?
Interpreter. (in Gujarati)	Do you produce phlegm when you cough?
Patient: (in Gujarati)	When I have a bad cold, then there is more phlegm
Interpreter:	Whenever she has a cold, there's phlegm
Doctor:	All right. Has she ever coughed up blood?

The interpreter has in this instance paraphrased the doctor's question, but an appropriate response has been obtained.

A model for the analysis of medical discourse of this kind was suggested in the Lancaster University D.O.P.A.C.S. papers (Candlin, Bruton and Leather 1974). We have chosen, at least for the moment, not to use such models for the reason suggested in our first paragraph. We believe that doctors would find such an account forbidding. This is not of course to say that functions other than the ones listed above do not appear in our transcripts (doctor greets, doctor reassures, doctor summarises etc) but they were marginal to the dominant pattern. More significantly, perhaps, we recorded no instances of patients asking the doctor questions.

It may be noted that in the speech sample above, nor elsewhere in the transcriptions, is there any evidence of 'foreigner talk' as defined by Ferguson (1975), presumably precisely because the doctor felt that his remarks were being translated accurately.

In the analysis of the transcripts we focussed on three areas: firstly, on the types of question which the doctor asked; secondly on the translation of terminology and thirdly on those aspects of the culture and sociology of the Gujarati family which, on the evidence, apparently impeded communication.

The Doctor's Questions

It seemed to us that in a bilingual interview a lot might depend on the grammatical form as well as on the content of questions. In our analysis we classified questions into three types:-

1. Simple - one clause questions
   e.g. "How long has she had the cough for?"
2. Complex - where one clause is embedded inside another

e.g. "Does she know what the diagnosis is?"

3. Serial - where the patient is asked alternative questions, or questions in series, or given a choice.
   e.g. "Right now, this pain, would she be able to describe it as sharp, or dull, or mmm a burning pain?
   Can she describe it at all?"

We hypothesised that the second type of question might place strains on the interpreter's cognitive processing of language, and the third on his or her memory. A study by Shuy (1974) in the United States in a monolingual setting showed that in question type 3 the patient tended to concentrate on the last item in the series, and neglect the rest. Our results seem clearly to bear out our hypotheses. The table below shows the proportion, expressed as a percentage, of the questions of each type which were mistranslated or not translated:-

Table 1

Consultation	Q Simple %	Q Complex %	Q Serial %	TOTAL
1	19	50	39	23
2	16	25	39	24
3	39	80	67	52
4	29	82	63	44

These results are consistent. In each case, simple questions caused least difficulty, 39% at worst. In three cases out of four, serial questions were next most difficult, 67% at worst. Even our two best interpreters mistranslated or did not translate almost a quarter of all questions. The message then would seem to be clear: doctors in bilingual interviews should keep their questions simple, as defined above. For the record, the response given to out type 3 question above was:

> "She says, you know, when you're going to take a breath and you can't take a breath, it's that kind of pain, sort of".

Terminology

Mistranslation can of course derive from lexis as well as from the processing of structures. There were more than eighty examples of terms mistranslated or not understood by at least one interpreter. Examples are given below, with equivalents of Gujarati translations, where given, in the right hand column.

Table 2

(i) Anatomical

Term	Translated as
abdomen	stomach
ankle	leg
calf	leg
chest	heart, soul
jaw	back teeth
ribs	chest
tonsil	neck

(ii) Symptoms and Conditions

Term	Translated as
asthma	breathlessness
breathlessness	no breath, waking up suddenly
bringing up phlegm	to spit out
diarrhoea	laxative, indigestion
epileptic fit	being mad
faeces	-
gynaecological	-
gallstones	-
indigestion	any stomach pain
passing motions	-
passing water	watery faeces
tightness of chest	pain in chest
tuberculosis	(T.B. was understood)

(iii) Other

Term	Translated as
appetite	frequency of eating
diagnosis	-
evening	late afternoon, night
family	(assumed to be on the male side)
lethargic	lazy, idle
medication	tablets
nationality	where born
night	dinner time, sleep time
swelling	getting fat
treatment	medicine, X ray
washed out	lazy

(iv) Euphemisms

Term	Translated as
back passage	back
water works	-

(v) Loan Words

Term	Translated as
trouble	pain (trouble can mean pain in Indian English)
cough	('kuf' means phlegm in Gujarati)

A similar but much briefer list appears in Medway (1985)

The anatomical mistranslations are easily explained. Gujarati does not 'cut up' the human body in exactly the same way as English, and there is particular confusion between parts of the body which are close to each other. On euphemisms, the doctor should avoid questions of the 'How are the waterworks?' type since our interpreters, at least, seemed to lack this kind of informal register. The list of 'other' terms above hints at different cultural perceptions e.g. in how the word 'family' can be perceived, which we will now discuss.

It can be pointed out at this stage that two of our four interpreters, at least in this context, seemed semi-lingual, adequate in neither English nor Gujarati.

Social and Cultural Factors

Consider the follwing exchanges:-

Doctor:	Do you know if Mrs C has even been told that she has tuberculosis? Could you ask her for me?
Patient: *(in Gujarati)*	What's he asking?
Interpreter: *(in Gujarati)*	He's asking if the doctor told you what I suspect, did he?
Patient: *(in Gujarati)*	No
Doctor:	All right, all right. But we know she has problems with her health.

Asian patients in general seem loth to admit to a history of tuberculosis in the family. The reason would seem to be that if such knowledge is disseminated in the community then the marriage chances of the family's sons and daughters can be affected, and a degree of social ostracism occur. We have then different perceptions about information which it is fitting to pass outside the family, even to a doctor. It is not unlikely that there are other similar taboo topics.

There seem also to be different perceptions about topics which can be discussed inside the family, and about who can discuss them. These relate in part to the positional and patriarchal nature of many Asian families, where the father in particular is the arbiter in such matters. We had one instance where when a wife was asked questions about serious illness in her family, the interpreter, her husband, responded to the doctor, with information about *his* family. The connotation of the term *family* was the male blood line.

Sons and daughters found it embarrassing to ask their mothers questions about menstruation and bowel movements and indeed there was a tendency for questions about bodily functions in general to be glossed over.

Finally, one of the most difficult problems in arriving at a case history was establishing a precise time scale. Time seemed not to be seen in a linear fashion, but rather as clustering round events in past lives. These events were in turn not sequenced, but seemed to flow into each other. Both the Hindu and Muslim calendars are of course lunar, with an imprecise relationship with Western years.

To sum up: we have here interviews which seemed on the surface, at least to the doctor, to be reasonably normal, but which were in fact for the linguistic and cultural reasons given severely dysfunctional. The quality of information given was such that a correct initial diagnosis was likely to be difficult. These conclusions must be tentative, since they are based on interviews with only four

patients by one doctor, but we feel that they are sufficiently striking for a more exhaustive study to be desirable.

Note

In the discussion which followed the paper, the question of interpreters in the National Health Service was discussed. Assuming the finance was forthcoming this would obviously be in most ways desirable. It could be questioned, however, whether an interpreter, if seen as from the community and having access to it, would be successful in eliciting information which the family regarded as sensitive.

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